NJDOH Q FEVER INVESTIGATION WORKSHEET CDRSS #: _____

DEMOGRAPHICS

Race
☐ White ☐ Black ☐ American Indian or Alaskan Native
☐ Asian ☐ Pacific Islander

Ethnicity
☐ Hispanic
☐ Non-Hispanic

Pregnancy status
☐ Pregnant ☐ Not Pregnant
☐ N/A ☐ Unknown

CLINICAL INFORMATION

Select a response for each sign or symptom below and include onset/resolution dates

Sign/Symptom	Response	Onset Date	Resolution Date
Abdominal pain	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Chills	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Cough	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Difficulty breathing	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Endocarditis	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Fever, Tmax _____	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Hepatitis	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Liver enlargement	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Malaise	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Myalgia	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Nausea	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Osteomyelitis	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Pneumonia	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Rash	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Severe retrobulbar headache	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Spleen enlargement	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Sweats (night)	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Thrombocytopenia	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____
Other:		_____ / _____ / _____	_____ / _____ / _____

Has this infection of Q Fever persisted more than 6 months?

☐ Yes

☐ No

☐ Unk.

Any pre-existing medical conditions?

☐ Immunocompromised
*specify condition(s)*_____

☐ Valvular heart disease or vascular graft

☐ Pregnancy

☐ Other *specify*_____

☐ Unknown

Was patient hospitalized because of this illness?

☐ Yes, *specify location and date(s)*
Hospital name:

Admission: _____ / _____ / _____

Discharge: _____ / _____ / _____

☐ No ☐ Unknown

Did the patient die because of this illness?

☐ Yes
*Date*____ / _____ / ____

☐ No

☐ Unknown

TREATMENT INFORMATION

Treatment	Dosage	Dates
☐ Doxycycline		____ / ____ / ____ to ___ / ____ / ____
☐ Trimethoprim/sulfamethoxazole		____ / ____ / ____ to ___ / ____ / ____
☐ Hydroxychloroquine		____ / ____ / ____ to ___ / ____ / ____
☐ Other:_____		____ / ____ / ____ to ___ / ____ / ____

Not treated

RISK FACTORS

Has this infection of Q Fever persisted more than 6 months? ☐ Yes ☐ No ☐ Unk.

Occupation

☐ Veterinarian
☐ Dairy
☐ Wool or felt plant
☐ Laboratory worker
☐ Live in a household with a person occupationally related
☐ Other, *specify* _____
☐ Rancher
☐ Tannery or rendering plant
☐ Slaughterhouse worker
☐ Animal research
☐ Medical research

In the 2 months prior to illness onset, did the patient have a tick bite?

☐ Yes *Date*: _____ / _____ / _____
☐ No
☐ Unk.

In the 2 months prior to illness onset, did the patient work on or visit a farm?

☐ Works on a farm *Location:*
☐ Visited a farm *Location:* *Date of visit:*
☐ Works on and visited a farm *Locations:* *Date of visit:*
☐ Unknown

Select responses for any animal contact within 2 months of illness onset?

Animal	Response	Date of first contact	Date of last contact	Location
Cattle	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____	
Sheep	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____	
Goats	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____	
Pigeons	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____	
Cats	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____	
Rabbits	☐ Yes ☐ No ☐ Unk.	_____ / _____ / _____	_____ / _____ / _____	
Other:		_____ / _____ / _____	_____ / _____ / _____	

In the 2 months prior to illness onset, did the patient have an exposure to birthing animals?

☐ Yes, *specify animal(s)* _____
First exposure: _____ / _____ / _____
Last exposure: _____ / _____ / _____

☐ No ☐ Unknown

In the 2 months prior to illness onset, did the patient consume unpasteurized milk/milk products?

☐ Yes
Type of milk product _____
Name of milk product _____
Where was the milk product purchased? _____
Date of first consumption: _____ / _____ / _____
Date of last consumption: _____ / _____ / _____

☐ No ☐ Unknown

In the 12 months prior to illness onset, did the patient travel outside of New Jersey?

☐ Yes
Location (specify state/county or country)_____
Date of arrival: _____ / _____ / _____
Date of departure: _____ / _____ / _____
☐ No
☐ Unk.

In the 12 months prior to illness onset, did the patient have other family members with similar illness?

☐ Yes
Date(s): ___ / ____ / ____ to ___ / ____ / ___

☐ No
☐ Unknown

ADDITIONAL CASE NOTES